DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 01-016

2. STATE: Iowa

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
April 1, 2001

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
Section 1932 of the Act

7. FEDERAL BUDGET IMPACT:
a. FFY 01 $ 0
b. FFY 02 $ 0

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Supplement 1 to Attachment 2.1-A, pages 1 through 20

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
None

10. SUBJECT OF AMENDMENT:
Conversion of medical managed health care to state plan service from a waiver service

11. GOVERNOR'S REVIEW *(Check One)*:

☑ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☐ OTHER, AS SPECIFIED:

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME:
Jessie K. Rasmussen

14. TITLE:
Director

15. DATE SUBMITTED:
April 25, 2001

16. RETURN TO:
Director
Department of Human Services
Hoover State Office Building
Des Moines, IA 50319-0114

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:
April 30, 2001

18. DATE APPROVED:
JUN 08 2001

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
APR 01 2001

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME:
Thomas W. Lenz

22. TITLE:
ARA for Medicaid and State Operations

23. REMARKS:

cc:
Rasmussen

SPA CONTROL

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

6. Non-MCO contractors will act as enrollment brokers in assisting eligible recipients in choosing among competing health plans in order to provide recipients with more information about the range of health care options open to them.

7. The state will share cost savings with recipients resulting from the use of more cost-effective medical care with recipients by eliminating co-payments for those who enroll into an MCO program. Co-payments will apply for those services provided under the MediPASS program.

8. The state requires recipients in MediPASS to obtain services only from Medicaid-participating providers who provide such services. Providers must meet reimbursement, quality, and utilization standards that are consistent with access, quality, and efficient and economic provisions of covered care and services. Recipients enrolled in MCO plans may be referred to any MCO-credentialed provider. The plan may also choose to allow non-emergency care to be provided by other practitioners on a case-by-case basis if it benefits the enrollee.

9. MediPASS will operate in all counties of the state except in those geographical areas without an adequate number of primary care case managers participating in MediPASS. The MCO program will operate in counties where MCOs have contracted with the state. Mandatory assignment will only occur if the recipient has a choice between at least two MediPASS PMs or a combination of one MCO and the MediPASS program.

B. Assurances and Compliance

1. Consistent with this description, the state assures that all the requirements of Sections 1932, 1903(m), and 1905(t) of the Social Security Act will be met.

2. The MHC program is available in selected counties in Iowa. Mandatory enrollment provisions will not be implemented unless a choice of at least two MediPASS PMs or a combination of MCO and the MediPASS program is available.

3. Iowa has safeguards in effect to guard against conflict of interest on the part of employees of the state and its agents.

4. Iowa will monitor and oversee the operation of the mandatory managed care program, ensuring compliance with all federal program requirements, federal and state laws and regulations, and the requirements of the contracts agreed upon by Medicaid and its contractors.

5. Iowa will evaluate compliance by review and analysis of reports prepared and sent to the Iowa Medicaid agency by the contractors. Deficiencies in one or more areas will result in the contractor being required to prepare a corrective action plan, which will be monitored by the Iowa Medicaid agency.

6. Reports from the grievance and complaint process will be analyzed and used for evaluation purposes.

7. Iowa staff will provide technical assistance as necessary to ensure that contractors have adequate information and resources to comply with all requirements of law and their contracts.

8. Iowa staff will evaluate each contractor for financial viability/solvency, access and quality assurance.

C. Target Groups of Recipients

The MHC program is limited to the following target groups of recipients:

1. Families, children, and pregnant women eligible for Medicaid under Section 1931 of the Social Security Act or related coverage groups.

2. Recipients eligible for Medicaid through the Medicaid expansion under the State Child Health Insurance Program (SCHIP). (Recipients in the Iowa's separate SCHIP program are not enrolled in managed health care.)

D. Mandatory Enrollment Exclusions

1. The following groups will not be enrolled in managed care:

   a. Dual Medicare – Medicaid eligibles.

   b. Recipients enrolled in the Medically Needy program.

   c. American Indians who are members of federally recognized tribes. Iowa's eligibility system (the Automated Benefit Calculation system) contains a field for ethnicity which caseworkers use to document whether a person applying for benefits is a member of a federally recognized tribe. This already existing indicator will be used to exempt American Indians from the mandatory enrollment process in Medicaid managed care.

      Currently, the Mesquaki Tribe is the only Federally recognized American Indian Tribe in Iowa. It is a subset of the Sac and Fox of the Mississippi. The Iowa Tribe has 1,277 enrolled members. The improving economic conditions on the Mesquaki Settlement, primarily due to casino revenue, have resulted in a significant growth trend and a 200% birth rate increase since 1992. The Automated Benefit Calculation system will identify any Mesquaki members (as well as members of other tribes) who participate in Medicaid.

d. Children under 19 years of age who are any of the following:

(1) Eligible for SSI under Title XIX.

(2) Described in Section 1902(e)(3) of the Social Security Act.

(3) In foster care or other out-of-home placement.

(4) Receiving foster care or adoption assistance.

(5) Receiving services through a family centered, community–based coordinated care system receiving grant funds under Section 501(a)(1)(D) of Title V. Recipients that are not excluded from enrollment under this subsection are defined as children with special health-care needs that are receiving direct financial assistance from the State's Maternal and Child Health Care program.

After consultation with the State's Maternal and Child Health agency, an agreement was made that these recipients will be identified using appropriate medical status codes from the Medicaid Management Information System and through a data file transfer undertaken monthly between the Title V Agency and the Department of Human Services. Any additional recipients that would be affected by this subsection will be requested to identify themselves in the enrollment process.

If Iowa's Maternal and Child Health Care program identifies any child for whom they are providing comprehensive services in that program who is enrolled in MHC, arrangements will be made to immediately disenroll the child from MHC with the appropriate exclusion code. Services provided to such children will not require authorization. Providers will be given emergency authorizations for claims processing until the child can be disenrolled.

e. Recipients who are residing in a nursing facility or ICF/MR.

f. Recipients who have an eligibility period that is only retroactive.

g. Recipients who participate in a home and community-based waiver.

h. Recipients who are older than 65 years of age.

i. Recipients who have commercial insurance paid under the Health Insurance Payment Program.

j. Recipients placed into the "lock-in" program by the Department after consultation with the Iowa Foundation for Medical Care.

E. Enrollment and Disenrollment

1. All recipients will be given the opportunity to choose from at least two MHC providers including enrollment into an MCO where this option is available. If a recipient has a prior provider relationship that they wish to maintain, the enrollment broker will assist the recipient in choosing a managed care entity that will maintain this relationship.

   Iowa contracts with an independent contractor to conduct the enrollment process and related activities. The enrollment broker performs services and supplies information as follows to facilitate the enrollment process:

   a. Under direction and oversight by the Department, recruit MediPASS patient managers for the PCCM model of the program.

   b. Review provider access for each county quarterly to assure appropriate primary care access for the enrollees.

   c. Answer MHC-related questions from recipients and providers.

   d. Prepare enrollment materials for MHC program, for Department approval, and store all MHC materials (MCO, MediPASS and MHC in general).

   e. Process new enrollment packets for those MHC eligibles identified by the Department.

   f. Process the recipient's choice of MHC option and send enrollments to the Department for inclusion on the next monthly medical card.

   g. Log all grievances and requests for special authorization from MediPASS enrollees.

   h. Review recipient's request for enrollment change during EPP for good cause.

   i. Perform various quality assurance activities for the MHC program. This includes but is not limited to; paid claim audits, 24-hour access audit, appointment system survey, encounter data validation, review and approval of special authorization for MediPASS enrollees, recipient and provider educational correspondence, and utilization review for MediPASS providers.

   j. Supplies an enrollment packet to the recipient that includes individual MCOs' informing materials and information supplied by the state.

k. Provides enrollment counseling which includes:

(1) Inquiring about patient/provider experience and preference.

(2) Providing information on which MCOs or MediPASS PMs are available to maintain a prior patient-provider relationship.

(3) Facilitating direct contact with individual MCOs, as necessary.

(4) Providing any information and education concerning the enrollment process, individual MCOs', benefits offered, the enrollment packet, and any of the other information provided for in this section.

l. If the recipient fails to choose an MCO or MediPASS PCCM provider within a minimum of 10 calendar days after receiving enrollment materials, the Department assigns the recipient to a PCCM or MCO.

m. Iowa allows MCOs/PHPs or primary care case managers to assist in enrolling beneficiaries. There are times when the MCO or the MediPASS provider's office might be the initial point of contact with the MHC recipient. In order to process the recipient's enrollment choice efficiently, the Department does allow for the enrollment choice to be communicated to the enrollment broker from the MCO or the MediPASS provider's office. However, there are some safeguards in place to ensure that the correct enrollment is processed and that the choice is truly from the recipient.

The MCOs' and MediPASS providers' offices are able to have a supply of MHC enrollment forms at their location. The enrollment form does require the signature of the case name (Medicaid applicant) in order to be accepted and processed by the enrollment broker. Telephone calls from either place will require that the person listed as the case name be on the phone making the enrollment choice.

2. Default enrollment will be based upon maintaining prior provider-patient relationships or, where this is not possible, on maintaining an equitable distribution among managed care entities.

3. Information in an easily understood format will be provided to beneficiaries on providers, enrollee rights and responsibilities, grievance and appeal procedures, covered items and services, benefits not covered under the managed care arrangement, and comparative information among managed care entities regarding benefits and cost sharing, service areas, and quality and performance (to the extent available).

4. Any selection or assignment of an MCO or PCCM may be changed at the request of the recipient for the following "good cause" reasons: poor quality of care, lack of access to special services or other reasons satisfactory to the Department. Some examples of these reasons would be if a new MHC option becomes available in the enrollees' county, or if a provider within a network were to leave and that provider's patients/enrollees wish to change options to continue the same doctor/patient relationship. Whenever an enrollee is receiving prenatal care, there is a 'good cause' reason for allowing the enrollee to change options to maintain the existing doctor/patient relationship. Recipients may disenroll at any time for good cause.

5. During the first 90 days of the initial enrollment and the first 90 days of enrollment each nine months after the date of the initial enrollment, the recipient can change from one MCO or PCCM to another without cause.

6. Enrollees will be provided notification 60 days before the end of a lock-in period of their opportunity to make a new choice of MCO or PCCM.

7. Enrollees will be given an opportunity to change MCOs or PCCMs and will be sent a notice to that effect.

8. MCOs and PCCMs will not discriminate against individuals eligible to be covered under the contract on the basis of health status or need of services.

9. The MCO and PCCMs will not terminate enrollment because of an adverse change in the recipient's health.

10. An enrollee who is terminated from an MCO or PCCM solely because the enrollee has lost Medicaid eligibility for a period of two months or less will automatically be re-enrolled into the same MCO or PCCM upon regaining eligibility.

11. As stated in Section E.5, an enrollment period shall not exceed nine months. An enrollee may disenroll following the initial 90 days of any period of enrollment if all of the following circumstances occur:

    a. The enrollee submits a request for disenrollment to the Department citing good cause for disenrollment.

    b. The request cites the reason or reasons why the recipient wishes to disenroll.

    c. The Department determines good cause for disenrollment exists.

12. The recipient will be informed at the time of enrollment of the right to disenroll.

13. An enrollee will be allowed to choose his or her health professional in the MCO to the extent possible and appropriate and will be allowed to change his or her health professional as often as requested per the policy of the MCO. Changes made for good cause are not considered as a request for change if the MCO sets a number of changes allowed yearly.

14. Enrollees will have access to specialists to the extent possible and appropriate and female enrollees will have direct access to women's health services.

F. Process for Enrollment in an MCO/PCCM

The following process is in effect for recipient enrollment in the MHC Program:

1. The Department shall provide beneficiaries with information in an easily understood format on providers, enrollee rights and responsibilities, grievance and appeal procedures, covered items and services, benefits not covered under the managed care arrangement, and comparative information among MCEs regarding benefits and cost sharing, service areas, and quality and performance (to the extent available).

2. All materials will be in an easily understood format (6th grade reading level or less). Materials will be translated into languages other than English if 10% of the population or 1,000 people in a service area speak a language other than English as their primary language.

3. Recipients will be able to select an MCO or PCCM from a list of available managed care entities in their county as well as those in contiguous counties. If the recipient wishes to remain with a primary care case manager or MCO with whom a patient/physician relationship is already established, the recipient is allowed to do so. Each recipient shall notify the Department by mail, telephone or in person, of his or her choice of plans. If voluntary selection is not made within the 10-calendar day period describe above, the Medicaid program shall assign an MCO or PCCM in accordance with the procedures outlined in E above.

4. As indicated in Section E, if the recipient does not choose a PM , the Department will assign the recipient to a PM and notify the recipient of the assignment.

5. The MCO and PCCM will be informed electronically of the recipient's enrollment in that MCO.

6. The recipient will be notified of enrollment and issued an identification card.

7. Additionally, each MCO will provide recipients the following information within ten days after notice of enrollment:

   a. Benefits offered, the amount, duration, and scope of benefits and services available.

   b. Procedures for obtaining services.

   c. Names and locations of current network providers, including providers that are not accepting new patients.

   d. Any restrictions on freedom of choice.

   e. The extent to which there are any restrictions concerning out-of-network providers.

   f. Policies for specialty care and services not furnished by the primary care providers.

   g. Grievance and appeal process.

   h. Member rights and responsibilities.

G. Maximum Payments

Section 1902(a)(30) of the Act and implementing regulations prohibit payments to an MCO contractor from exceeding the cost to the agency of providing these same services on a fee-for-service basis to an actuarially equivalent nonenrolled population. Iowa fee-for-service costs are considered in the development of the upper payment limit and the managed care rates. The contract with the actuary requires that calculated rates shall be actuarially sound and consistent with the upper payment limit requirement at 42 CFR 447.361. State payments to contractors will comply with the upper payment limit provisions in 42 CFR 447.361.

H. Covered Services

1. Services not covered by the MHC program will be provided under the Medicaid fee-for-service program. Medicaid recipients will be informed of the services not covered under the MHC Program, the process for obtaining such services. The State assures that the services provided within the managed care network and out-of plan and excluded services will be coordinated. The required coordination is specified in the state contract with MCOs and PCCMs and is specific to the service type and service provider.

2. MCOs are encouraged to develop subcontracts or memoranda of understanding with federally qualified health centers (FQHCs) and rural health clinics (RHCs) as well as family planning clinics.

3. Preauthorization of emergency services and emergency post stabilization services and family planning services by the recipient's MCO is prohibited. Recipients will be informed that emergency and family planning services are not restricted under the MHC Program. "Emergency services" are defined in the MCO contract and Iowa Administrative Code 441--88.

4. The PCCM shall be responsible for managing the services marked below in column (7). The MCO capitated contract will contain the services marked below in Column (4). All Medicaid-covered services not marked in those columns will be provided by the Iowa Plan (under the requirements of that program) or Medicaid fee for service (without referral). Mental health and substance abuse treatment services are provided under the Iowa Plan for Behavioral Health under the current 1915(b) waiver in effect for those services.

Service (1)	State Plan Approved (2)	1915(b)(3) Waiver Services (3)	MCO/PHP Capitated Reimbursement (4)	Fee-for-Service Reimbursement Impacted by MCO/PHP (5)	Fee-for-Service Reimbursement for MCO/PHP (6)	PCCM Referral/ Prior Auth. Required (7)	Wraparound Service Impacted by PCCM (8)	PCCM Referral/Prior Authorization Not Required or Non-Waiver Services (9)
Day Treatment Services	X		X			X		
Dental	X				X			X
Detoxification	X		X					?
Durable Medical Equipment	X		X			X		
Education Agency Services	X				X			X
Emergency Services	X		X					X
EPSDT	X		X					X
Family Planning Services	X				X			X
Federally Qualified Health Center Services	X		X			X		
Home Health	X		X			X		
Hospice	X		X			X		

Service (1)	State Plan Approved (2)	1915(b)(3) Waiver Services (3)	MCO/PHP Capitated Reimbursement (4)	Fee-for-Service Reimbursement Impacted by MCO/PHP (5)	Fee-for-Service Reimbursement for MCO/PHP (6)	PCCM Referral/ Prior Auth. Required (7)	Wraparound Service Impacted by PCCM (8)	PCCM Referral/Prior Authorization Not Required or Non-Waiver Services (9)
Inpatient Hospital – Psych	X				X			X
Inpatient Hospital – Other	X		X			X		
Immunizations	X		X					X
Lab and X-ray	X		X			X		
Nurse Midwife	X		X			X		
Nurse Practitioner	X		X			X		
Nursing Facility	X				X			X
Obstetrical Services	X		X			X		
Occupational Therapy	X		X			X		
Other Fee-for-Service Services	X		X			X		
Other Psych. Practitioner	X				X			X
Outpatient Hospital – All Other	X		X			X		
Outpatient Hospital – Lab & X-ray	X		X			X		
Partial Hospitalization	X		X			X		
Pharmacy	X				X			X
Physical Therapy	X		X			X		
Physician	X		X			X		
Prof. & Clinic and Other Lab and X-ray	X		X			X		
Psychologist	X				X			X

Service (1)	State Plan Approved (2)	1915(b)(3) Waiver Services (3)	MCO/PHP Capitated Reimburse ment (4)	Fee-for-Service Reimburse-ment Impacted by MCO/PHP (5)	Fee-for-Service Reimburse-ment for MCO/PHP (6)	PCCM Referral/ Prior Auth. Required (7)	Wraparound Service Impacted by PCCM (8)	PCCM Referral/Prior Authorization Not Required or Non-Waiver Services (9)
Rehabilitation Treatment Services	X				X			X
Respiratory Care	X		X			X		
Rural Health Clinic	X		X			X		
Speech Therapy	X		X			X		
Substance Abuse Treatment	X				X			X
Testing for Sexually Transmitted Diseases	X		X			X		
Transportation – Emergency	X		X			X		
Transportation - Non-emergency	?		?			?		
Vision Exams and Glasses	X			X				X

I. Mandates

1. In the MCO program, Iowa will enter into contracts with State licensed MCOs. Iowa will enter into comprehensive risk contracts with the MCOs. These organizations will arrange for comprehensive services, including inpatient or outpatient hospital, laboratory, x-ray, physician, home health, early periodic screening, diagnosis and treatment, family planning services and all other Medicaid optional services, except for those described in Section H.1.

   All contracts will comply with Sections 1932 and 1903(m) of the Act. All contracts Iowa has selected the MCOs that operate under the MHC program in the following manner: Iowa has used and will use an open cooperative procurement process, in which any qualifying MCO/PHP that complies with federal procurement requirements and 45 CFR Section 74 may participate. The Department requires all participating MCOs to be licensed by the Iowa Department of Commerce, Insurance Division. This licensure also identifies the MCO service area, by county in the state. The Department sets the capitation rates by region in the state and any participating MCO must accept those rates for the respective Medicaid covered services.